DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

CORRECTED

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **02 - 02**	2. STATE: **Texas**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: **July 1, 2002**	

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **Social Security Act §1915 (g)**	7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY **2002** **$ 235,757** b. FFY **2003** **$ 955,226**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **SEE ATTACHMENT**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **SEE ATTACHMENT**

10. SUBJECT OF AMENDMENT:

Amendment 621 creates a new rate for case management provided to individuals through the Texas Department of Mental Health and Mental Retardation MRLA waiver program.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comment, if any will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL: Linda K Wertz DB	16. RETURN TO: **Linda K. Wertz** **State Medicaid Director** **Post Office Box 13247** **Austin, Texas 78711**
13. TYPED NAME: **Linda K. Wertz**	
14. TITLE: **State Medicaid Director**	
15. DATE SUBMITTED: **July 25, 2002**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 17 June 2002	18. DATE APPROVED: 5 August 2002
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 July 2002	20. SIGNATURE OF REGIONAL OFFICIAL: Calvin G. Cline
21. TYPED NAME: CALVIN G. CLINE	22. TITLE: ASSOCIATE RETIONAL ADMINISTRATOR DIV OF MEDICAID AND STATE OPERATIONS

23. REMARKS:

FORM HCFA – 179 (07-92)

Attachment to HCFA – 179 for
Transmittal No. 02-02, Amendment No. 621

Number of the Plan Section or Attachment	Number of the Superseded Plan Section or Attachment
Supplement 1 to Attachment 3.1-A	Supplement 1 to Attachment 3.1-A
Page 1B.1	Page 1B.1 (TN95-15)
Page 1B.2	Page 1B.2 (TN00-13)
Page 1B.3	Page 1B.3 (TN95-15)
Page 1B.4	New Page
Attachment 4.19-B	Attachment 4.19-B
Page 15	Page 15 (TN00-09)
Page 15a	Page 15a (TN99-03)
Page 15b	Page 15b (TN00-09)

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Revision: HCFA-PM-87-4 (BERC) SUPPLEMENT 1 TO ATTACHMENT 3.1-A
Page 1.B
OMB No. 0939-0193

STATE PLAN UNDER TITLS XIX OF THE SOCIAL SECURITY ACT
State/Territory: Texas

CASE MANAGEMENT SERVICES

A. Target Group: Mental retardation or related conditions or pervasive developmental disability

See attachment

B. Areas of State in which services will be provided:

☒ **Entire State.**

☐ **Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide**

C. Comparability of Services

☐ **Services are provided in accordance with section 1902(a)(10)(B) of the Act.**

☒ **Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.**

D. Definition of Services

See attachment

E. Qualification of Providers:

See attachment

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CASE MANAGEMENT SERVICES For Individuals with Mental Retardation or Related Condition or a Pervasive Developmental Disability

A. **Target Population**

There are two categories of Medicaid eligible individuals with mental retardation or related condition or a Pervasive Developmental Disability that receive case management services.

1. individuals with mental retardation or a related condition **or pervasive developmental disability** and require long term care in the community **who are not receiving services through the Mental Retardation Local Authority Program (MRLA)**.

2. individuals with mental retardation or a related condition or pervasive developmental disability who are receiving services through the Mental Retardation Local Authority Program (MRLA).

- Mental retardation is defined as significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and originating during the developmental period. Subaverage general intellectual functioning refers to measured intelligence on standardized psychometric instruments of two or more standard deviations below the age group mean for the tests used. Developmental period means the period of time from conception to 18 years. Arrest or deterioration of intellectual ability that occurs after this period is functional retardation and does not meet the definition of mental retardation. Related condition is defined as a severe, chronic disability that meets the criteria outlined in 42 CFR §435.1009. **Pervasive developmental disorder (PDD) is characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities that meet the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.**

B. **Definition of Services for Individuals Not Receiving Services Through MRLA**

Case management activities are provided to assist Medicaid eligible individuals with mental retardation or a related condition in gaining access to medical, social, educational, and other appropriate services that will help them achieve a quality of life and community participation acceptable to each individual. The role of persons who provide case management activities is to support and assist the person in achieving personal goals. Case management is provided regardless of age.

Case management activities include:

- **Screening and Assessment:** Obtaining client-identifying information and identifying the nature of the presenting problem and service and support needs of the individual which are documented.
- **Crisis Intervention:** Locating and coordinating emergency services which are documented in writing.
- **Service Planning and Coordination:** Identifying and arranging for the delivery of services and supports that address the individual's needs which are documented in writing. This includes community reintegration planning during the last 180 consecutive days of a Medicaid eligible person's stay in a Medicaid certified acute care facility, Nursing Facility (NF), Institution for Mental Diseases (IMD) for individuals age 65 or older and children under the age of 21, or Intermediate Care Facility for the Mentally Retarded;
- **Monitoring:** Evaluating the effectiveness of the services and the need for additional or different services that are documented in writing.

C. Service Limitations for Individuals Not Receiving Services through MRLA

Case Management activities will not be reimbursable as a Medicaid service if another payor is liable or, if the activities are associated with the proper and efficient administration of the state plan. Case management activities associated with the following are not reimbursable as targeted case management service:

- Medicaid eligibility determinations and redeterminations;
- Medicaid eligibility intake processing;
- Medicaid preadmission screening;
- Prior authorization for Medicaid services;
- Required Medicaid utilization review;
- Texas Health Steps administration; and
- Medicaid "lock-in" provided for under Section 1915(a) of the Omnibus Reconciliation Act of 1987.

Specifically, reimbursement will not be made for:

- Services that are an integral and inseparable part of another Medicaid service;
- Discharge planning from an institution for mental diseases (except for individuals age 65 or older and children under the age of 21);
- Outreach activities that are designed to locate individuals who are potentially Medicaid eligible;
- Any medical evaluation, examination, or treatment billable as a distinct Medicaid covered benefit; however, referral arrangements and staff consultation for such services are reimbursable as case management activities; or
- Services provided under the Home and Community Based Services Waiver for Mentally Retarded Individuals.

D. Service Coordination Definitions for MRLA

- **IPC (individual plan of care) – A document that describes the type and amount of each HCS program service component to be provided to an individual and describes medical and other services and supports to be provided through non-program resources.**
- **LAR (legally authorized representative) – A person authorized by law to act on behalf of a person with regard to a matter described in this subchapter, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.**
- **MRLA – Mental Retardation Local Authority Program is a 1915(c) waiver operated by TDMHMR.**
- **PDP (person-directed plan) – A plan developed for an applicant that describes the supports and services necessary to achieve the desired outcomes identified by the applicant or the applicant's LAR on behalf of the applicant.**

E. Service Limitations for Service Coordination through MRLA.

MRLA service coordination activities will not be reimbursable as a Medicaid service for which another payor is liable. Service coordination activities associated with the following are not reimbursable as a targeted case management service:

- **Medicaid eligibility determinations and redeterminations;**
- **Medicaid eligibility intake processing;**
- **Medicaid preadmission screening;**
- **prior authorization for Medicaid services;**
- **required Medicaid utilization review;**
- **Texas Health Steps administration; and**
- **Medicaid "lock-in" provided for under §1915(a) of the Omnibus Reconciliation Act of 1987.**

Reimbursement will be made for the following MRLA service coordination activities:

- **Assist the individual in all activities necessary to complete and maintain MRLA eligibility;**
- **Initiate, coordinate, and facilitate the person-directed planning process to meet the desires and needs as identified by the individual and the individual's legally authorized representative (LAR) on behalf of the individual;**
- **Coordinate the development and implementation of each individual's Person Directed Plan (PDP).**
- **Assist in the performance of resource authorization including submission of a correctly completed request for authorization of payment from non-MRLA Program services for which an individual may be eligible;**
- **Coordinate and develop the IPC from the PDP;**
- **Coordinate and monitor the delivery of MRLA Program and generic services;**
- **Integrate various aspects of services delivered under the MRLA Program and through other sources;**
- **Record each individual's progress;**
- **Develop discharge and transfer plans, when necessary;**
- **Keep records as they pertain to the individual receiving services;**
- **Ensure that an individual under 18 years of age who is unable to live with his or her natural family members lives in a family-based alternative;**
- **Complete a Permanency Planning Review Screen and submit the information electronically to TDMHMR for each individual under 22 years of age who is receiving supervised living or residential support upon enrollment.**

If the service coordinator in conjunction with the service planning team determines that the individual under 18 years of age is not able to return to the family home or move to a family-based alternative or a person from 18 to 22 years of age is unable move to a consistent and nurturing environment as determined by the individual and LAR, the service coordinator must complete a Permanency Planning Review Screen and submit the information electronically to TDMHMR every six months to obtain approval from the TDMHMR commissioner to continue to provide such services.

F. Qualifications of Providers

Section 4118(I) of P.L. 100-203 Omnibus **Budget** Reconciliation Act of 1987, is invoked limiting the provider of case management activities to the State Mental Retardation Authority, which is the Texas Department of Mental Health and Mental Retardation (TDMHMR), or local authorities designated in accordance with **§534.054** if the Texas Health and Safety Code.

TDMHMR has implemented rules, standards, and procedures to ensure that case management activities are:

- Available on a statewide basis with procedures to ensure continuity of services without duplication;
- Provided by persons who meet the requirements of education and work experience commensurate with their job responsibilities as specified by TDMHMR; and
- In compliance with federal, state, or local laws, including directives, settlements, and resolutions applicable to the target population.

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22. Case Management for individuals with mental retardation or a related condition **or pervasive developmental disability**.

Reimbursement for case management services for individuals with mental retardation or a related condition **or pervasive developmental disability** is subject to the specifications, conditions, and limitations required by HHSC or its designee. These include the specifications provided in OMB Circular A-87 and A-102.

The statewide reimbursement rates for the case management services program are interim throughout the rate period and subsequently adjusted to cost. HHSC or its designee determines statewide reimbursement rates at least annually, but may determine them more often if deemed necessary. The reimbursement rates are based upon allowable costs, as specified by HHSC or its designee, or qualified staff, travel, facility, and administrative overhead expenditures. The unit of service is one face-to face contact per month.

Claims for reimbursement for case management services include:

- date of service;
- name of recipient;
- identifying Medicaid number;
- address;
- name of provider agency;
- unit(s) of service delivered; and
- place of service

Reimbursement rates are determined in the following manner.

1. Inclusion of certain reported expenses. Provider agencies must ensure that all requested costs are included in the cost report for administrative claiming. All references to cost reports are the cost reporting process for administrative claiming. Failure to do so may result in penalties.

2. Several different kinds of data are collected. These include the number of units of service. The cost data include direct costs programmatic indirect costs and general and administrative overhead costs.

a. Case management is an activity performed by a qualified case manager employed by the provider agency, with the person served to assess needs, and locate, coordinate and monitor necessary services. **Two rates are** set for services provided to individuals **with mental retardation or a related condition or pervasive developmental disability. The two rates are for:**

- **individuals** with mental retardation or a related condition **or pervasive developmental disability** and require long term care in the community **who are not receiving services through the Mental Retardation Local Authority Program (MRLA)**.

- **individuals with mental retardation or a related condition or pervasive developmental disability who are receiving services through the Mental Retardation Local Authority Program (MRLA)**.

b. The cost data include direct costs, programmatic indirect costs, and general and administrative costs including salaries, benefits, and non-labor costs. Programmatic indirect costs include salaries, benefits and other costs of this case management program that are indirectly related to the delivery of case management services to clients. General and administrative overhead costs include the salaries, benefits and other costs that, while not directly part of the case management services program, constitute costs that support the operations of the case management services program. Providers must eliminate unallowable expenses from the cost report. Unallowable expenses included in the cost report are omitted from the cost report database and appropriate adjustments are made to expenses and other information reported by providers; the purpose is to ensure that the database reflects costs and other information which are consistent with efficiency, economy, and quality of care; are necessary for the provision of covered case management services; and are consistent with federal and state Medicaid regulations. If there is doubt as to the accuracy or allowableness of a significant part of the information reported, individual cost reports may be eliminated from the database.

3. Rate setting methodology for case management for persons **with mental retardation or a related condition or pervasive developmental disability**

a. Providers will be reimbursed a statewide interim rate comprised of modeled costs for direct care plus a statewide weighted average for reported indirect costs. The modeled costs for direct care rate is based on cost calculations that include a statewide weighted average hourly wage for persons who provide case management as 100 percent of their job responsibilities, a predetermined caseload size **of 45 for case managers providing case management outside of the MRLA program and 25 for case managers providing case management through the MRLA**, a statewide weighted average supervisory wage rate and span of control, and a statewide weighted average benefits factor. The associated indirect costs collected through the cost reporting process for administrative claiming include clerical and support costs, travel and training costs, and other allowable operating costs such as rent, utilities, office supplies, administration, and depreciation necessary to provide case management. Following each annual reimbursement period, each provider's actual allowable costs will be compared to interim reimbursement and any resulting monetary reconciliation will be made in accordance with item 6 of this section.

Total costs are projected from the historical reporting period to the interim rate period. Cost projections adjust the allowable historical costs for significant changes in cost-related conditions anticipated to occur between the historical cost period and the prospective rate period. Significant conditions include, but are not necessarily limited to, wage and price inflation for deflation, changes in program utilization and efficiency, modification of federal or state regulations and statutes. Appropriate economic adjusters as described in state regulations, are determined to calculate the projected expenses. The Personal Consumption Expenditures (PCE) Chain-Type Index, which is based on data from the U. S. Department of Commerce, is the most general measure of inflation and is applied to salaries and benefits, materials, supplies, and services.

Rates are adjusted if new legislation including the appropriations, regulations or economic factors affect costs, as specified in state regulations. Cost data will be collected to supplement the cost report to capture costs not reported during the historical reporting period.

b. For the non-modeled component for the interim rates, provider costs by unit of service are arrayed from low to high. HHSC may exclude or adjust certain expenses in the cost report database in order to base rates on the reasonable and necessary costs that an economical and efficient provider must incur. Statistical outliers (those providers who unit costs exceed +/- two standard deviations of the mean) are removed. The mean projected total cost per unit of service is calculated after statistical outliers have been removed and this becomes the recommended reimbursement rate.

4. Reimbursement setting authority. HHSC determines reimbursement rates after consideration of financial data, statistical information and public testimony.

5. Reviews of cost report disallowances. A contracted provider may request notification of the exclusions and adjustments to reported expenses made during either desk reviews or onsite audits, according to state regulations. Contracted providers may request an informal review and, if necessary, an administrative hearing to dispute the action taken by the HHSC or its designee under state law.

6. If a provider's costs exceed the statewide rate, TDMHMR will reimburse the provider its costs up to 125 percent of the statewide rate. If a provider's costs are less than 95 percent of the statewide rate, the provider will pay TDMHMR the difference between the provider's costs and 95 percent of the statewide rate.

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